

IDAHO DEPARTMENT OF

HEALTH & WELFARE

C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 2, 2007

Mr. Louis Kraml, Administrator Bingham Memorial Hospital 98 Poplar Street Blackfoot, ID 83221

Provider #131325

Dear Mr. Kraml:

On May 21, 2007, a Complaint Investigation was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00002902

Allegation #1: Staff failed to close the door and ensure a patient's privacy during the provision of care following an incontinence episode.

Findings:

An unannounced visit was made to investigate the complaint. During the investigation, observations were made on the medical-surgical unit and current patients were interviewed.

Observations were made and interviews were conducted on 5/21/07 between 2:45 and 3:15 PM on the medical-surgical unit. During the observation period, staff were observed to knock before entering patient rooms and to close the doors of rooms in which patient cares were being provided. No patients were noted to be exposed at the time of the observations.

Three of six current patients were interviewed. The patients stated staff were courteous and treated them with respect. They stated staff protected their privacy by closing their doors during personal care activities.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

No privacy issues were identified and no deficiencies were cited.

Allegation #2: During hospitalization, a patient fell and experienced a fractured leg. The hospital said it was looking into the incident, but no written response was provided to the patient.

Findings: During the unannounced investigation, staff were interviewed and reviews were conducted of medical and administrative records, policies and the hospital's grievance process.

Closed medical records for five patients, who were admitted with similar diagnoses, were reviewed. One record contained documentation related to a patient fall. X-rays were taken of the patient's left leg. The X-rays were read by a radiologist. The report stated there were "no bony abnormalities" and "the joint spaces and soft tissues were normal".

An incident report was completed at the time of the fall and had been reviewed per policy. Following communication with the patient/family, the incident was referred to the Care Concern Resolution Committee. The patient's record was sent for medical staff peer review. Findings of that review were documented 5/2/07. Staff stated, during interview on the afternoon of 5/21/07, that the hospital's risk manager was reviewing all of the findings and would then provide a written response to the patient.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Hospital policies were followed and no deficient practice was identified. No deficiencies were cited.

Allegation #3: A patient's call light was placed out of reach. The patient attempted to get up to the bathroom and fell.

Findings: During the unannounced investigation, observations were made on the medical-surgical unit and current patients were interviewed.

Observations were made and interviews were conducted on 5/21/07 between 2:45 and 3:15 PM on the medical-surgical unit. During the observation period, current patients' access to call lights was evaluated. Three of six patients were noted to be in bed. Each patient's call light was noted to be either in their hand or in easy reach. Three patients were out of bed, one in a chair and two in wheelchairs. Their call lights had been placed where they could reach them.

Three of six current patients were interviewed. The patients stated staff made sure they could reach their call lights before leaving the room. They stated staff reminded them to call them if they wanted to get out of bed or if they needed anything. They stated staff responded to their calls for assistance in a timely manner.

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Conclusion: Unsubstantiated. Lack of sufficient evidence.

No quality of care issues were identified and no deficiencies were cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PENNY SALOW

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Supervisor

Non-Long Term Care

PS/mlw